

Bureau Talk

September 2014

Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>



Corporate Offices

Corporate offices continue to request correspondence from the bureau. However, the bureau sends all correspondence and concerns to the administrators of the entities it regulates, not to corporate offices or directors of nursing. An administrator is responsible for all aspects of an agency. There is no exception to this requirement.

Correspondence

When administrators correspond with the bureau by postal service or email, they must include their agency's Medicare provider number. Agencies may have similar names or may have changed their names. An agency's provider number allows the bureau to identify the correspondence.



Per both home health and hospice regulations, any administrator change must be approved by an agency's governing body. The bureau must see board meeting minutes signed by an identified board member who approved the change.

This requirement can be found at CFR 484.14(b), CFR 418.100(b) and at 19CSR 30-35.010(1)(A)(15).

Missouri Medicare Case Reviews

Effective Aug. 1, 2014, Missouri patients and providers will no longer call Primaris for Medicare quality-review casework and appeals. They should call KEPRO toll-free at 1-855-408-8557. KEPRO is located in Seven Hills, Ohio.

The Centers for Medicare & Medicaid Services (CMS) awarded the contract to KEPRO as part of the first phase of restructuring the Quality Improvement Organization (QIO) program. The program's case review and monitoring activities have been separated from its quality improvement activities.

All outstanding Higher-Weighted DRG medical record requests after Aug. 1 should be mailed to: KEPRO, 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609.



Your organization should take several steps during this transition. It should:

- Update all copies of the Notice of Medicare Non-Coverage. That notice informs beneficiaries that Medicare may stop paying for their care;
- Replace all print and electronic copies of beneficiary resources that include Primaris' contact information; and,
- Update policies and procedures that contain a reference to contacting Primaris.

For more information on the QIO program, visit www.QIOprogram.org or call 1-800-MEDICARE. For more information about Primaris, please visit www.primaris.org.



Agencies play a vital role in protecting the integrity of Medicare. **Attachment A**, titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," gives providers the tools they need to protect their organization and Medicare. The fact sheet defines Medicare fraud and abuse and the laws used to address both, and gives overviews of partnerships among government agencies engaged in fighting the suspected crimes and resources on how to report them. For instance, providers can call the Office of Inspector General's Hotline at 1-800-HHS-TIPS (1-800-447-8477) to report suspected Medicare fraud and abuse. They can also email HHSTips@oig.hhs.gov.

License Renewals

DBA

Frequently when agencies submit a license renewal application, their legal or "doing business as (DBA)" name does not match the name the bureau has on file. An agency administrator should notify the bureau in writing if his or her agency changes names. All legal names or doing-business-as names must be registered with the Missouri Secretary of State's office. **Attachment H** can guide agencies with this process.

Home Health

New CMS Home Health Guidance



The May 2014 Bureau Talk contained an article titled “New CMS Home Health Survey Guidance.” That article referred to Survey & Certification (S&C) Letter 14-14-HHA and its attachments. Since then, the Centers for Medicare & Medicaid Services (CMS) revised that letter and its attachments and republished them on May 20, 2014 (see **Attachment G**).

Attachment G offers valuable guidance to home health agencies and includes the following:

- State operations manual (SOM) Chapter 9 changed to Chapter 10. Chapter 10 guides State Agencies (SA) and Regional Offices on imposing HHA sanctions and the procedures regarding an informal dispute resolution (IDR) process. The Office of Strategic Operation and Regulatory Affairs determined that the Chapter 9 designation was already in use.
- SOM, Chapter 2, Certification Sections 2180-2202.19 — An error in section 2202.10 resulted in two corrections.
- Recent establishment of these survey and enforcement regulations, and changes to other HHA policies necessitated revisions to Appendix B. There have been no changes to Chapter 10 since the original publication of S&C Letter 14-14 HHA.

The regulations pertaining to directed in-service training, temporary management, and directed plans of correction became effective July 1, 2013. The provisions pertaining to the imposition of civil monetary penalties and suspension of payment for new admissions, and the provisions for the informal dispute resolution process became effective July 2, 2014.



Hospice Issues

Hospice Volunteers

On May 15, 2014, Health Facilities Nursing Consultant Judy Morris hosted a teleconference for the Missouri Hospice & Palliative Care Association titled “Hospice Volunteer Program.” She presented an in-depth look at the federal and state regulations that address hospice volunteers and the most frequent volunteer-related hospice citations. Judy also encouraged questions and shared the most frequent ones the bureau receives about hospice volunteers.

Attachment B includes Judy’s presentation. The individual handouts she provided are also attached and include:

- Missouri Regulations on Hospice Volunteer Orientation (**Attachment C**)
- Volunteers’ Questions & Answers (**Attachment D**)
- Frequent Hospice Citations Regarding Volunteers (**Attachment E**)
- Volunteer Presentation Websites (**Attachment F**).

Home Health

OASIS C-1

CMS has made interim changes to OASIS-C1, scheduled to be implemented on 10/01/2014. (Some providers may have already printed and reviewed this new data set.) The interim changes were necessary because five data items in OASIS-C1 require ICD-10 codes, and ICD-10 won't be implemented until at least 10/01/2015.

The five items — M1011, M1017, M1021, M1023, M1025—have been replaced with OASIS-C's corresponding ICD-9 items (M1010, M1016, M1020, M1022, M1024).



Other changes to OASIS-C1 include time-point revisions, typographical error corrections, descriptive terminology in some data items, the use of words rather than abbreviations ("e.g." replaced with "for example"), word clarification, a new pressure ulcer item (M1309), and more.



CMS posted the modified OASIS-C1, called "OASIS-C1/ICD-9 Version," on 6/16/2014. The document can be downloaded from the bureau website at <http://health.mo.gov/safety/homecare/>. Click on "OASIS," and then click on "OASIS-C1." The OASIS-C1-ICD-9 Version will go into effect with any M0090 date on or after midnight Jan. 1, 2015, and shall remain in effect until ICD-10 is implemented or

CMS makes another disposition/decision.

CMS has assured the OASIS education coordinators that the OASIS-C1/ICD-9 Version mirrors existing OASIS-C guidance. Most of the changes support current OASIS Chapter 3 guidance and Q&As. If your agency is current with OASIS-C guidance, the transition to the OASIS-C1/ICD-9 Version should not be difficult.

CMS has posted other documents to coincide with the OASIS-C1/ICD-9 Version release. The documents include:

- Draft files of the OASIS-C1/ICD-9 Chapter 3 Guidance; and,
- The 6/2014 OASIS C-1/ICD-9 Version of the OASIS Category Questions & Answers, posted on 7/16/2014. This information provides guidance on data collection for the OASIS-C1/ICD-9 data set.

The documents are also available at <http://health.mo.gov/safety/homecare/>.

Home Health

Clarification of OASIS Questions

Joyce Rackers received several questions that are confusing to providers and shares CMS guidance about the questions below.

1) The first question involves how to handle OASIS if a patient has an inpatient admission and returns to an agency in the same 60-day period. Below please find the CMS Q&A (Q21.1, Category 4b).



Q: New text in the “Medicare Claims Processing Manual, CMS Publication 100-4, Chapter 10,” reads, “A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, the discharge is not recognized for Medicare payment purposes. All the home health services provided in the complete 60-day episode, both before and after the inpatient stay, should be billed on one claim.” Does this mean that providers should never do an RFA 7 (transfer with discharge)?

A: When a Medicare Traditional fee-for-service patient is transferred to an inpatient facility, the patient should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay, an RFA 6 should be completed. There will be times when the RFA 7 is necessary to use, but only when the HHA does NOT anticipate the patient will be returning to care. There are several reasons why the RFA 7 may be used, including these examples: the patient needs a higher level of care and is no longer appropriate for home health care, the patient’s family plans on moving the patient out of the service area, or the patient is no longer appropriate for the home health benefit.

The Claims Processing Manual clarified this issue in July 2010. It directs providers not to discharge a patient when goals are unmet at the time of a transfer. If a provider does discharge and readmit within this same 60-day payment episode, a Partial Episodic Payment (PEP) adjustment will be automatically made.

These instructions apply only to Medicare Traditional fee-for-service patients. Follow payer-specific guidance for other payers.

(continued on Page 7)

Home Health

Clarification of OASIS Questions

(continued from Page 6)



2) The second issue involves how to answer M1000 on the SOC when a patient is admitted to an inpatient facility for less than 24 hours.

Q: We had a client who was admitted to an inpatient facility for less than 24 hours. We did not do an OASIS Transfer because the criteria for it were not met. Two days later the patient was discharged from our agency and we completed a discharge comprehensive assessment. Approximately one week later, the client developed a wound and was readmitted to our agency. When completing the new SOC comprehensive assessment, how do we mark M1000 regarding Inpatient Facility Discharge in the Past 14 Days?

A: M1000 asks if the patient were discharged from an inpatient facility during the past 14 days. In your scenario, you describe a patient who was admitted and discharged from an inpatient facility during the 14 days prior to the completion of the new RFA 1 SOC comprehensive assessment. The inpatient stay would be reported in M1000.

M1000 does not ask you to report only inpatient facility stays that meet the criteria for the OASIS Transfer, i.e., it does not require that the stay in the inpatient facility is for 24 hours or greater for reasons other than diagnostic testing. It simply asks whether the patient was discharged from an inpatient facility during the past 14 days. Please see CMS Q&A Category 4b, Q32.2.

Home Health



OASIS-C

Though information is flowing about the OASIS-C1/ICD-9 Version, providers should continue to keep up-to-date on OASIS-C guidance. Agencies should follow that guidance and must use the OASIS-C data set until Jan. 1, 2015.

The July 2014 CMS OASIS Quarterly Q&As can be accessed at www.qtso.com. Click on "OASIS," and then click on "User Guide & Training." These new Q&As contain important clarification about maintaining accurate data collection. Issues addressed include:

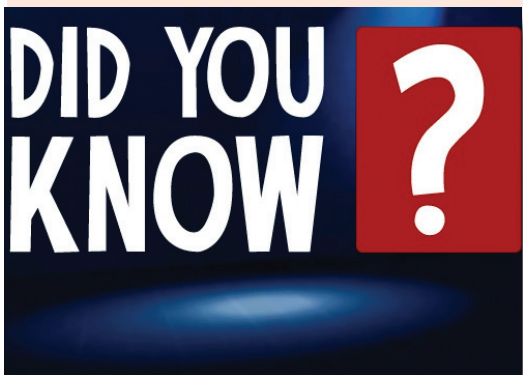
- How to answer M1030 if infusion is discontinued prior to OASIS assessment;
- Clarification for M1100 when a patient is living in a continuum of care complex and has a call bell;
- Clarification of when to consider herbal supplements as medications when answering medication data items;
- Use of "usual status" convention for M1860;
- How to answer M2250(e) when aspirin is used as an anticoagulant; and,
- Important information regarding accurate emergent-care reporting.

Q&As that relate to the new OASIS-C1/ICD-9 Version include:

- Assessment timing for implementing the OASIS-C1/ICD-9 Version;
- Clarification of OASIS-C1 language changes for the flu vaccine and worsening of pressure ulcer items;
- Clarification of the new OASIS-C1/ICD-9 Version data item M1309; and,
- How to answer M2250(d) and M2400(c) if a clinician does not receive physician acknowledgment.

Please print the attached Q&As and share with your clinicians. Remember, clinicians who are current with OASIS-C guidance will have a much smoother transition to the OASIS-C1/ICD-9 Version.

OASIS...Did You Know?



- For M1850, you are also assessing the patient's ability to transfer safely back to a sleeping surface.
- If answering OASIS-C correctly, the M0090 date on the SOC will likely not coincide with a skilled clinician visit.
- Agencies should have a policy directing their clinicians as to when an M0100 RFA (Reason for Assessment) 5 or other follow-up should be conducted.
- Agencies should be conducting RFA 5s or other follow-ups anytime a major decline or improvement in a patient's health status occurs.
- For M0102, if a date is entered, a physician's order should be documented in the clinical record.

Home Health



OASIS Technical

OASIS-C1/ICD-9 Version Data Submission Implications

1. Conversion to the Assessment Submission and Processing (ASAP) System

Effective Jan. 1, 2015, OASIS assessment data will be submitted to CMS via the national OASIS Assessment Submission and Processing (ASAP) system. Home health agencies will no longer submit OASIS assessment data to CMS via their state databases.

Agencies need to know the following to transition data from state databases to the national ASAP system.

- The state-based OASIS submission system will shut down permanently at 6:00 p.m. (EST) on Dec. 26, 2014.
- The OASIS ASAP system will become available at midnight (EST) on Jan. 1, 2015.
- OASIS assessment data collected from 6:00 p.m. (EST) on Dec. 26, 2014, through Dec. 31, 2014, at 11:59 p.m. (EST), may be submitted to the ASAP system on or after Jan. 1, 2015.

2. Implementation Plan & OASIS Data Submission Process

For OASIS assessment data files submitted on or after Jan. 1, 2015:

- They must be submitted using the ASAP system;
- Submission of OASIS-C data must be done using version 2.10 of the OASIS data submission specifications (which support OASIS-C); and,
- Submission of OASIS-C1 data must be done using version 2.11 of the OASIS data submission specifications (which support OASIS-C1).

3. Payment Grouper Updates

- An updated home health payment grouper will be provided to accommodate OASIS assessment data submitted on or after Oct. 1, 2014, using the OASIS-C data item set and ICD-9CM codes.
- Another updated home health payment grouper will be provided to accommodate OASIS assessment data submitted on or after Jan. 1, 2015, using the OASIS-C1/ICD-9 Version and ICD-9-CM codes.
- CMS also plans to release a home health payment grouper update to accommodate assessments submitted Oct. 1, 2015.
- CMS will provide follow-up announcements at later dates regarding the release dates for the updated home health payment grouper software for the grouper updates listed above.



.....

Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336. Hearing- and speech-impaired citizens can dial 711.

*AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
Services provided on a nondiscriminatory basis.*